PRINTED: 05/20/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			B. WING			03/29/2011	
			D. (12)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	UTLER RD		
HAMILTO	N HOUSE				WAYNE, IN46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
R0000	Complaint IN00 Complaint IN00 substantiated, stathe allegations ar R0247, and R034 Survey dates: Ma Facility number: Provider number AIM number: Survey team: Christine Fodrea, Rick Blain, RN (Ann Armey (Man Census bed type: Residential: Total: 35 Census payor typother: 35 Total: 35 Sample: 5 These State findiaccordance with	088036 was the deficiencies related to re cited at R240, R0241, 49. arch 25, 28 and 29, 2011 0004686 : 0004686 NA , RN, TC March 25, 2011) rch 28, 2011) see: ngs are cited in 410 IAC 16.2		0000	The submission of this plan response and the plan of correction included in is not legal admission that a defici exist or that this statement deficiencies was correctly ci. This is also not to be construed as an admission against into by facility or any employee a and other individuals who do may be discussed in this response and plan of correction. In addition prepare and submission of this plan of correction does not constitute admission or agreement of a kind by the facility of the truttent any fact alleged or the correction of any conclusions set forth allegation by the survey age.	ency of ted. ucted erest agents raft or ration f te an any th of ctne in this	(V6) DATE
LABUKATUK	I DIKECTOK'S OK PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	JINAI UKE		HILE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0L4J11

Facility ID:

004686

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D		(X3) DATE) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
			B. WIN			03/29/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				UTLER RD		
наміі тс	N HOUSE				WAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEI (CLERCI)		DATE
	_ ` •	ompleted on March 31,					
	2011, by Bev Fau	ılkner, RN					
D0240	(d) Porsonal care	and assistance with					
R0240		ving, shall be provided					
		dual needs and preferences.					
	•	ew and record review,	RO	240	Residence Director and Well	ness	04/30/2011
		to implement care as			Director will frequently sched		
	•	sident service plan for 1			care conference with Reside	nt	
		riewed for turning and			and spouse to ensure that Residents needs are being		
		a total sample of 5.			met.Residence Director and		
	(Resident #N)	total sample of 5.			Wellness Director have set a		
	(Resident #11)				system in place to ensure that	at	
	Findings in deal				Resident service plans are		
	Findings include	-			reviewed regularly and are accurate. Any significant cha	ngo	
	Davidout //Nilaaa				of condition warrants an upda		
		cord was reviewed			resident service plans. Resid		
		30 a.m., Resident #N's			Director and or Wellness Dire	ector	
	_	ed but were not limited to			will ensure that updates are		
	_	ood pressure, and high			dated.Residence Director an		
	cholesterol.				Wellness Director have retra staff to show how changes in		
					resident care are		
	Resident #N's As	ssessment and Negotiated			communicated.Residence		
	Service Plan Sun	nmary, dated 2-2-2011,			Director and or Wellness Dire	ector	
	under the heading	g Special Services, Other,			will monitor care delivery,		
	3 points for frequ	ent turning. The			document action twice week ensure completion until 100%		
	checkmark for ot	ther, 3 points and -for			compliance is achieved. Reg		
		had been handwritten on			Director of Quality and Care		
		was no date on the			Management and or regional		
		y to indicate when the			Director of operations will		
	plan was updated	,			randomly audit documentation		
	Pian was apaared				during routine house visits at least monthly for the next 6		
	A Short Tarm Ch	ange of Condition			months and there after as		
		10-2011, indicated			needed.		
	Report, dated 3-1	10-2011, maicaica					
			1		I		ı l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	IG		03/29/2	011
NAME OF 1	PROVIDER OR SUPPLIER	- {		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	JTLER RD		
HAMILTO	ON HOUSE			FORT V	VAYNE, IN46815		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		s to be repositioned					
	1 1	pdated Short Term					
		ition Report dated					
		ated a turning schedule					
	had been posted	for signing.					
		Service notes, dated					
	3-10-2011, indic	eate a 1 1/2 inch scabbed					
	area had been no	oted on the right hip					
	trochanter are.						
	In a confidential	interview with a facility					
	staff member on	3-28-2011 at 2:30 p.m.,					
	the interviewee i	indicated there was no					
	communication	of Resident #N needing					
		sitioning until the					
		e developed the pressure					
	area.	at the pressure					
	In an interview o	on 3-28-2011 at 3:30 p.m.,					
		rector indicated she was					
		service plan had been					
		ade frequent turning.					
		ade nequent turning.					
	In an interview	on 2 28 2011 at 2.50 n m					
		on 3-28-2011 at 3:50 p.m., ed Resident #N had not					
		ording to the schedule in					
	the room at time	S.					
	A :	Construction of the Construction					
		turning and repositioning					
	_	ed by the Administrator					
		8:30 a.m., indicated the					
		tioning documentation					
	had not been init	tiated until 3-18-2011 at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING B. WING	OCONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/29/2011
	PROVIDER OR SUPPLIER		2116	ET ADDRESS, CITY, STATE, ZIP CODE BUTLER RD T WAYNE, IN46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE PROVIDER'S PLAN OF CORRECT PROVIDER'S PLAN OF		(X5) COMPLETION DATE
R0241	include document repositioning had at 8 a.m.; 3-21 at and 2 p.m.; 3-22 a.m.; 3-23 at 4 a. 2, 6, 8, and 10 p. at 8 p.m.; and 3-2 On page 3 the Ref 7-2006, indicated provide the level determined by the assessment and N This Residential Complaint IN000 (e) The administration of reside as ordered by the	esident Handbook, dated I "The Residence will of assistance as e resident's individual Negotiated Service Plan."			
	premises or on cal (1) Medication shallicensed nursing p medication aides. Based on intervie facility failed to a given as ordered 5 residents review	Il as follows: Ill be administered by ersonnel or qualified ew and record review, the ensure medications were by the physician for 2 of wed for medication a total sample of 5.	R0241	Resident N and O had no adverse effects from not recomedications. An audit of curl Resident Medication Administration Records will I conducted by the Wellness Director or deignee to ensur	rent De
	Findings include	:		medications have been administered and ordered as indicated by staff initials.The	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			(X3) DATE SURVI	EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			A. BUII B. WIN			03/29/2011	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				JTLER RD		
HAMILTON HOUSE				1	VAYNE, IN46815		
HAMILIC	DINTIOUSE			FORT	VATNE, IN40015		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Qualified Medical Assistants	I	
	1. Resident #N's	record was reviewed on			be re educated on the rights	of	
	3-25-2011 at 11:	30 a.m. Resident #N's			Medical Administration and		
	diagnoses includ	ed but were not limited			proper documentation on the medication administration re	I	
	_	blood pressure and high			including explanations of circ	I	
	cholesterol.	olood pressure and mgn			medications. The Wellness		
	CHOICSICIOI.				Director or designee will revi	ew	
					the medication administration	ı	
		arch physician's orders			records twice weekly to ensu	re	
	indicated he was	to receive Flaxseed Oil			compliance with proper		
	1000 mg 2 times	per day initially ordered			documentation for six weeks	-	
	6- 28-2010, Neu	rontin 300 mg at bedtime			until consistent compliance heen achieved. The Residen		
	initially ordered	11-15-2010 and Ceftin			Director and or Regional Dire		
	<u>-</u>	per day an antibiotic			od Quality Care and Manage		
		3-7-2011 to be given for			will randomly audit a sample		
		nary tract infection.		medical administration records for			
	10 days 101 a uiii	nary tract infection.			compliance during routine ho	use	
	D 11 . //27 3.4				checks at least monthly.		
		Iarch 2011 Medication					
		Record indicated he was					
	scheduled to rece	eive the Flaxseed Oil,					
	Neurontin, and C	Ceftin at 8 a.m. and 8 p.m.					
	The Medication	Administration Record					
	also indicated a c	circle around the initials					
	for the Ceftin at	8 p.m. on 3-9-2011.					
		cumentation on the back					
		n Administration record					
	_	he initials had been					
		als were completed and					
		e 8 p.m. Flaxseed oil and					
	8 p.m. Neurontin	l.					
	A nurse's note, da	ated 3-9-2011, with no					
		p.mevening dose					
	medications were	_					
	incurcumons were	inibbou.					

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR' OO COMPLETE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		
			B. WING		03/29/2	2011
NAME OF F	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE	•	
				BUTLER RD		
HAMILTO	ON HOUSE		FOR	T WAYNE, IN46815		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		s-28-2011 at 2:30 p.m.,				
	`	ed she had been the staff				
	member responsi	2 2				
		3-9-2011 at 8 p.m., but				
		usy on the evening of				
	3-9-2011 and had	d completely forgotten to				
	give the medicat	ions, Flaxseed Oil,				
	Nuerontin, and C	Ceftin. She further				
	indicated she had	d initialed the				
	medications as g	iven, but the medications				
	should have been	n circled and an				
	explanation com	pleted on the back of the				
	Medication Adm	inistration Record to				
	indicate why the	medications had not been				
	given.					
	<i>Q</i>					
	2. Resident #O's	record was reviewed				
	3-25-2011 at 11 a	a.m. Resident O's				
		ed diabetes, high blood				
	_	onary artery disease.				
	pressure, and cor	onary artery disease.				
	Resident #O's ph	ysician's orders indicated				
	1	ve Flaxseed Oil 1000 mg				
	2 times per day i	•				
	6-28-2011.	milany ordered				
	0-20-2011.					
	 Resident #O's M	arch 2011 Medication				
		Record indicated she was				
		eive the Flaxseed Oil at 8				
	a.m. and 8 p.m.					
	_	ecord had initials to				
	indicate the Flax	seed Oil had been given.				
	J.,	to 4				
	in a confidential	interview with a staff				

PRINTED: 05/20/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	03/29/20	
			B. WIN			03/29/20	J 1 1
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE JTLER RD		
HAMILTO	N HOUSE				VAYNE, IN46815		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	member on 3-25-	-2011 at 12:05 p.m., the					
	interviewee indic	eated Resident #O had not					
	received her 8 p.1	m. medication on					
	3-9-2011.						
	In an interview 3	-28-2011 at 2:30 p.m.,					
	QMA #2 indicate	_					
	extremely busy o						
		d completely forgotten to					
	give the medicati	ion. She further indicated					
	the medication sh	nould have been circled					
	and an explanation	on completed on the back					
	of the Medication	n Administration Record					
	-	he medication had not					
	been given.						
	Page 14 of the Re	esident Handbook					
	_	Administrator 8-25-2011					
		licated the residence					
	·	with medicationsin					
	accordance with	state law.					
		11 D G ::					
		ellness Resource Guide,					
	dated 1-2010, inc						
	services must be	muatea.					
	This Residential	finding relates to					
	Complaint numb	•					
R0247		edication administration ne resident 's record. The					
		notified of any error in					
	medication admini	stration when there are any					
	actual or potential resident.	detrimental effects to the					
	resident.						

004686

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2116 BUTLER RD HAMILTON HOUSE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Resident N and O had no Based on interview and record review, the R0247 04/30/2011 adverse effects from not receiving facility failed to ensure a missed medications. An audit of current medication dose was noted in the residents' Medication resident's record for 1 of 5 residents Administration Records will be conducted by the Wellness reviewed for medication documentation in Director and/or designee to a total sample of 5. (Resident #O). ensure that medication have been adminitered and ordered as Findings include: indicated by staff initials. The Qulaified Medical Assistant will be retrained on the five rights of Resident #O's record was reviewed medicatio administration and 3-25-2011 at 11 a.m. Resident O's proper documentation on the diagnoses included diabetes, high blood Medication pressure, and coronary artery disease. Administration Records. Including explanations of circled medications. The Residence Resident #O's physician's orders indicated Director and/or degignee will she was to receive Flaxseed Oil 1000 mg re-educate the staff regarding notification and documentation of 2 times per day initially ordered this. When a medication has 6-28-2010. been missed and there is a potential detrimental effect. The Resident #O's March Medication Wellness Director and/or deignee Administration Record indicated she was will review the Medication Administration Records twice scheduled to receive the Flaxseed Oil at 8 weekly to ensure compliance with a.m. and 8 p.m. The Medication proper documentation for six Administration record had initials to weeks or until compliance had indicate the Flaxseed Oil had been given. been achieved. The Residence Director and/or Regional Director of Quality Care Management will In a confidential interview with a staff randomly audit a sampling of member on 3-25-2011 at 12:05 p.m., the Medication Administration interviewee indicated Resident #O had not Records for compliance during routine house visits at least received her 8 p.m. medication on monthly. Staff will be re-educated 3-9-2011. completing Medication Adminitration Records and In an interview 3-28-2011 at 2:30 p.m., Resident Service Notes correctly. The Residence Director QMA #2 indicated she had been

004686

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 03/29/2	ETED	
	PROVIDER OR SUPPLIER	R	2116 BI	ADDRESS, CITY, STATE, ZIP CODE UTLER RD WAYNE, IN46815	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3	(X5) COMPLETION DATE
	3-9-2011 and ha give the medicate she had initialed however the medicate she had initialed however the medicated and an extensive the back of the Market Record to indicate had not been give A review of the Resident #O did between 1-28-20 information relatemedication not be an interview of the Wellness Direct medication that the been documente notes. On 3-29-2011 at Administrator processive and the documentation of the second color of the sec	Resident Service notes for not include an entry 011 and 3-10-2011. The 11 did not include ting to the Flaxseed Oil being given. On 3-25-2011 at 2:10 p.m., ector indicated the was missed should have d in the Resident Service 9:45 a.m., the rovided a policy entitled ions dated 7/2009. The dicated the proper for missed medications.		and/or Wellness Director we review current resident recensure that resident record Medication Administration Records are in compliance	ords to s and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
			B. WIN	G		03/29/2	011
NAME OF PROVIDER OR SUPPLIER HAMILTON HOUSE				2116 BU FORT V	ADDRESS, CITY, STATE, ZIP CODE JTLER RD VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
R0349	on each resident. maintained under employee of the faresponsibility. The (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on intervie facility failed to emedications were in the medical recreviewed for medications were a total sample of Findings include: Resident #O's recreated a total sample of Findings include: Resident #O's recreated a total sample of Findings include: Resident #O's ph she was to receive 2 times per day in Resident #O's Madministration Resident #O's Madministra	sible. organized. ew and record review, the ensure missed e accurately documented cord for 1 of 5 residents dication documentation in 5. (Resident #O) : cord was reviewed a.m. Resident O's ed diabetes, high blood onary artery disease. ysician's orders indicated re Flaxseed Oil 1000 mg nitiated 6-28-2011. arch Medication decord indicated she was eive the Flaxseed Oil at 8	R0	349	Staff will be retrained regarding proper documentation protocol. Resident was not affected as a result from this deficient practice. The Qualification protocol for passing medications. The Wellness Director and/or Deignee will review new orders weekly to ensure proper transcription of Physician orders on the Medication Administration Records. Finding will be review and corrected through our Quand Care Management and/or Regional Director of Quand Care Management and/or Regional Dorector of Operativill randomly elect records to review during routine ite visit least monthly.	ed on of ewed A ess. lity or ions	05/06/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	onstruction 00	(X3) DATE COMPI - 03/29/2	LETED	
	PROVIDER OR SUPPLIER		2116 BI	ADDRESS, CITY, STATE, ZIP CO JTLER RD VAYNE, IN46815		
	SUMMARY S (EACH DEFICIENT REGULATORY OR at 12:05 p.m., the Resident #O had medication on 3- In an interview 3 QMA #2 indicate extremely busy of 3-9-2011 and had give the medicat she initialed the been given, howe should have been explanation com Medication Admindicate why the given. In an interview of the Wellness Dirmedication that we been circled on the Administration For Routine medication of the documentation for the decomposition of the de	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) e interviewee indicated not received her 8 p.m. 9-2011. 1-28-2011 at 2:30 p.m., ed she had been on the evening of d completely forgotten to ion. She further indicated medication as if it had ever, the medication in circled and an pleted on the back of the inistration Record to medication had not been on 3-25-2011 at 2:10 p.m., ector indicated the was missed should have the Medication Record. 9:45 a.m., the ovided a policy entitled ions dated 7/2009. The dicated the proper or missed medications. finding relates to			OULD BE	(X5) COMPLETION DATE